



JAN 11 2001

Memorandum

Date
*Michael Mangano*From
Michael Mangano
Acting Inspector GeneralSubject
Review of Medicare Payments for Beneficiaries Reported as Institutionalized by Penn State
Geisinger Health Plan (A-03-00-00010)To
Robert Berenson, M.D.
Acting Deputy Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on January 16, 2001, of our final report entitled, "Review of Medicare Payments for Beneficiaries Reported as Institutionalized by Penn State Geisinger Health Plan." A copy of the report is attached.

The Health Care Financing Administration (HCFA) pays a higher capitation rate for risk based enrollees who are institutionalized. Risk-based contractors submit to HCFA each month a list of enrollees meeting the institutional status requirements. The objective of our review was to determine if beneficiaries Penn State Geisinger Health Plan (PSGHP) reported as institutional status between January 1, 1997 and December 31, 1999 were institutionalized for the period(s) PSGHP received enhanced Medicare capitation payments.

To accomplish our objective, we reviewed a random sample of 100 beneficiary records from the universe of 1,528 Medicare beneficiaries reported as institutionalized by PSGHP. We found that PSGHP incorrectly reported the institutional status for 34 of the 100 Medicare beneficiaries in our sample resulting in overpayments of \$35,639. Based on our statistical sample of claims, we estimate total Medicare overpayments to be \$306,269. We bring this to your attention because the 34 percent error rate is substantial, and in prior reviews across the country, we had highlighted to HCFA problems with payments for institutional beneficiaries.

We recommended that PSGHP: (1) refund the specific overpayments of \$35,639 identified in the sample; (2) review the balance of 1,428 beneficiaries reported in institutional status between January 1, 1997 and December 31, 1999 and not included in our random sample to identify and refund additional overpayments (total overpayments are estimated to be \$306,269); (3) review the records of institutional status beneficiaries identified since December 31, 1999 and refund any overpayments; and (4) strengthen the internal controls for identifying, monitoring, and billing the Medicare program for institutional status beneficiaries.

The PSGHP agreed that errors occurred during our audit period resulting in overpayments but did not agree to our recommended financial adjustment. We disagree with the plan's

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reluctance to promptly make our recommended financial adjustment. Our review identified a significant 34 percent error rate in cases reviewed and the plan concurred with the majority of our findings. Therefore, we continue to recommend for an immediate refund of \$35,639 with the remainder to be settled pending the outcome of the plan's review of institutional members.

If you need additional information about this report, please contact either George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at 410-786-7104 or David M. Long, Regional Inspector General for Audit Services, Region III, 215-861-4501.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PAYMENTS
FOR BENEFICIARIES REPORTED AS
INSTITUTIONALIZED BY PENN STATE
GEISINGER HEALTH PLAN**



Inspector General

JANUARY 2001

A-03-00-00010



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region III
150 S. Independence Mall West
Suite 316
Philadelphia, PA 19106-3499

CIN: A-03-00-00010

Mr. Richard G. Slaughter
Vice President, Health Plans
Medicare
Geisinger Health System, M.C. 3020
100 North Academy Avenue
Danville, Pennsylvania 17822-3020

Dear Mr. Slaughter:

This final report presents the results of our REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES REPORTED AS INSTITUTIONALIZED BY PENN STATE GEISINGER HEALTH PLAN (PSGHP)¹. The purpose of our review was to determine if monthly capitation payments received by PSGHP for 1,528 beneficiaries that PSGHP had reported as institutionalized for the period January 1, 1997 through December 31, 1999 were appropriate. Our review was based on a random sample of 100 beneficiary records. Our review found that PSGHP received \$35,639 in Medicare overpayments for incorrectly reporting 34 Medicare beneficiaries in institutional status. Based on our sample results, we estimate total Medicare overpayments to be \$306,269.

We recommend that PSGHP: (1) refund the specific overpayments of \$35,639 identified in the sample; (2) review the balance of 1,428 beneficiaries reported as institutional status between January 1, 1997 and December 31, 1999 and not included in our random sample to identify and refund additional overpayments (total overpayments are estimated to be \$306,269); (3) review the records of institutional status beneficiaries identified since December 31, 1999 and refund any overpayments; and (4) strengthen the internal controls for identifying, monitoring, and billing the Medicare program for institutional status beneficiaries.

¹At the time of our review, the Health Care Financing Administration (HCFA) contract was with the Penn State Geisinger Health Plan. Currently, the Geisinger Health Plan is no longer affiliated with Penn State University.

On October 12, 2000, PSGHP responded to a draft of this report. The PSGHP agreed that errors occurred during our audit period resulting in overpayments but did not agree to our recommended financial adjustment. We have summarized the plan's response along with our comments after the Conclusions and Recommendations section of this report. The plan's written response is included as APPENDIX B.

BACKGROUND

The PSGHP administers a Medicare managed care program that provides health benefits in 28 Pennsylvania counties under the brand name Penn State Geisinger Health Plan Gold. As of May 2000, PSGHP's membership totaled 48,109 Medicare beneficiaries. The Medicare benefits are provided through a risk-based contract with HCFA under section 1876 of the Social Security Act (Act).

Risk-based plans are paid on a per-capita premium set at approximately 95 percent of the projected average expenses for fee-for-service beneficiaries in a given county. Risk-based plans assume full financial risks for all care provided to Medicare beneficiaries. In addition to Medicare-covered services, most plans, including PSGHP, offer additional services such as prescription drugs and eyeglasses.

Monthly payments to managed care plans are adjusted for the expected costs of each individual. The HCFA assigns weights by risk class based on age and sex and by status. Special status beneficiaries receive hospice, end stage renal disease, and/or institutional services. They also include beneficiaries classified as working aged or eligible for Medicaid.

The HCFA's Operational Policy Letter Number 54 (OPL 97-54) issued July 24, 1997 states that, effective January 1, 1998, to qualify under institutionalized status an enrolled member must have been a resident of one of the following Title XVIII of the Act (Medicare) or Title XIX of the Act (Medicaid) certified institutions for at least 30 consecutive days immediately prior to the month for which payment is made: a skilled nursing facility, a nursing facility, an intermediate care facility for the mentally retarded, a psychiatric hospital, a rehabilitation hospital, a long-term care hospital, or a swing-bed hospital. Prior to 1998, HCFA classified institutions as "nursing homes, sanatoriums, rest homes, convalescent homes, long-term care hospitals, and domiciliary homes." The 30-day stay rule was also in effect and could be found in HCFA's Contractor Performance Monitoring System Reviewers Work Guide.

The HCFA pays a higher capitation rate for risk based enrollees who are institutionalized. The HCFA requires risk-based contractors to submit to HCFA each month a list of enrollees meeting the institutional status requirements. Each month the plan subsequently adjusts the advanced payments. In 1999, PSGHP received a monthly advance of \$425.51 for each male beneficiary in Schuylkill County, Pennsylvania between 70 and 74 years old. The Medicare monthly payment for PSGHP for similar beneficiaries residing in institutional settings was \$980.16.

The HCFA regional office conducted a performance review of PSGHP operations in September 1999. This review disclosed weaknesses in PSGHP's verification system for institutional status beneficiaries. The HCFA recommended that PSGHP complete a 100 percent audit of institutional status cases from September 1997 (the date of HCFA's previous performance review).

SCOPE

Our review was conducted in accordance with generally accepted government auditing standards. The purpose of our review was to determine if 1,528 beneficiaries that PSGHP had reported in institutional status between January 1, 1997 and December 31, 1999 were institutionalized for the period(s) that PSGHP received enhanced capitation payments.

To achieve our objective, we first reviewed PSGHP's internal controls, focusing on procedures for verifying the institutional status of Medicare beneficiaries. We then selected a random sample of 100 beneficiary records from the universe of 1,528 Medicare beneficiaries reported as institutionalized by PSGHP. From PSGHP, we obtained the name, address, telephone number, and contact person of the institutions where the beneficiaries in our sample were purported to have resided. We forwarded letters to 54 facilities to determine if the 100 beneficiaries in our sample were institutionalized for the periods that PSGHP reported to HCFA. We compared the sample results with HCFA enrollment and payment data.

Based on responses received from the facilities, we identified those Medicare beneficiaries who were incorrectly reported as institutional status. For each error, we calculated the Medicare overpayment by subtracting the non-institutional payment that PSGHP should have received from the payment actually received. We projected the estimated value of Medicare overpayments to the population of 1,528 beneficiaries. Our statistical analysis is shown in APPENDIX A.

Our review was conducted at PSGHP offices in Danville, Pennsylvania and our regional office in Philadelphia, Pennsylvania between April 2000 and June 2000.

RESULTS OF REVIEW

ERRORS IN CLASSIFYING THE INSTITUTIONAL STATUS OF MEDICARE BENEFICIARIES RESULTED IN OVERPAYMENTS OF AT LEAST \$306,269

The PSGHP incorrectly reported the institutional status for 34 Medicare beneficiaries in our sample that resulted in overpayments of \$35,639. Based on this sample, we estimate total Medicare overpayments to be \$306,269. The 34 errors include:

- ▶ 16 beneficiaries who did not meet the residency requirement of 30 consecutive days immediately prior to the month for which payment is made. These 16 overpayments averaged \$479 per member per month for a total of \$7,669².
- ▶ 14 beneficiaries who were discharged from institutions and, therefore, did not meet the residency requirement of 30 consecutive days. The PSGHP continued to classify these 14 beneficiaries as institutionalized an average of 3 months. One beneficiary was classified as institutionalized for 18 additional months after discharge. These 14 overpayments averaged \$1,677 for a total of \$23,475².
- ▶ 4 beneficiaries who resided in personal care homes after January 1998. Personal care homes do not meet the institutional definition found in OPL 97-54. Therefore, PSGHP should not have reported the four beneficiaries as institutionalized. These four overpayments averaged \$1,124 for a total of \$4,494².

INTERNAL CONTROLS

The PSGHP did not have adequate internal controls to monitor the status of institutionalized beneficiaries. Specifically, our review found that PSGHP's institutional database included beneficiaries who: (1) did not meet the 30-day uninterrupted stay criteria, (2) were discharged from institutions, or (3) resided in facilities that did not meet HCFA's definition of an institution.

In August 2000, PSGHP submitted revised policies and procedures for HCFA's review. These policies, which are currently operational, are intended to ensure the correct classification of members' institutional status. The revised policies include HCFA's 30 consecutive day stay requirement. However, since these new procedures were not in effect during our audit period, we are unable to comment on their effectiveness in eliminating errors identified during our review.

The new procedures were in response to HCFA's September 1999 performance review which determined that PSGHP did not verify continued stays for institutional status beneficiaries. The HCFA noted that PSGHP should verify the institutional status after the last day of the month and prior to reporting to HCFA. The HCFA could not document that verification was proper or done at all.

CONCLUSION AND RECOMMENDATIONS

Our review found that PSGHP incorrectly reported the institutional status of 34 Medicare beneficiaries in our sample. As a result, PSGHP received Medicare overpayments of \$35,639. Based on this sample, we estimate that PSGHP received \$306,269 in Medicare overpayments between January 1, 1997 and December 31, 1999. The PSGHP violated HCFA guidelines that require a 30-day uninterrupted residency and specify the types of facilities that meet the institutionalized definition. In its performance review of PSGHP in September 1999, HCFA found weaknesses with the reporting of institutional status beneficiaries. The HCFA

²Difference due to rounding.

recommended that PSGHP review its institutional status records back to September 1997. We recommend that PSGHP:

- (1) refund the specific overpayments of \$35,639 identified in the sample;
- (2) review the balance of 1,428 beneficiaries reported in institutional status between January 1, 1997 and December 31, 1999 and not included in our sample to identify and refund additional overpayments (we estimate the total overpayments to be \$306,269);
- (3) review the records of institutional status beneficiaries identified since December 31, 1999 and refund any overpayments; and
- (4) strengthen the internal controls for identifying, monitoring, and billing the Medicare program for institutional status beneficiaries.

PSGHP RESPONSE AND OIG COMMENTS

In its comments to our draft report, the plan did not agree with 4 of the 35 sample errors identified by the Office of Inspector General (OIG). The four in dispute are listed in the plan's response in Appendix B. While agreeing that errors did occur in the classification of institutional status beneficiaries, the plan did not agree to our recommended financial adjustment. The plan believes that our sample was potentially skewed by including the period April through August 1999 when it was converting computer systems and was vulnerable to mistakes. Hence, it is reluctant to resolve its financial obligation to HCFA at this time. The plan proposed a complete manual audit of its Medicare members between January 1, 1997 and December 31, 2000 to be completed by March 31, 2001. Upon completion of its review, the plan will settle with HCFA. Finally, the plan stated that it continues to work on strengthening its internal controls for identifying, monitoring, and billing Medicare for institutional status beneficiaries.

We are pleased that the plan concurs with our recommendations to perform a review of its members reported as institutional status and strengthen its internal controls for identifying, monitoring, and billing the Medicare program for institutional status beneficiaries.

We agree that the fourth case cited in the plan's response should not be an error and have adjusted this final report accordingly. The first two cases did not meet the HCFA requirement of residency for at least 30 consecutive days immediately prior to the month for which payment is made. Although these stays occurred before OPL-54 was in effect, HCFA policy on this matter remained unchanged. The HCFA's OPL-54 was issued to clarify the types of facilities that meet HCFA's definition of an institution. For the third case, the facility confirmed to the OIG that the beneficiary was hospitalized for a period greater than 15 days and, therefore, did not meet the residency requirement.

We disagree with the plan's reluctance to promptly make our recommended financial adjustment. The plan's contention that our statistical sample was potentially skewed has no factual basis.

Our sample items were randomly selected and projected to the complete universe of claims. The plan's institutional members throughout our audit period of January 1, 1997 to December 31, 1999 had an equal chance to be selected. The sample does not draw from one time period and project to another one. The possibility that errors are identified in a sample unit and projected over a 3-year period that includes different processing methods does not invalidate the statistical validity of the results. The plan fails to take into account the possibility that correct payments, identified as \$0 errors, drawn from lower-risk periods within the time frame under review, are also projected to higher-risk periods that are part of the entire population from which claims were drawn. If there was an appreciable difference in the incidence of error from one processing period to another, this is accounted for in the resulting measure of the standard error and the determination of the confidence interval used to estimate the overpayment.

An analysis of our sample results also does not support the plan's position. Overall we found that 34 of 100 sampled items contained errors (34 percent error rate). Of the 100 sample items reviewed, 36 were from the period April to August 1999, and 8 of these contained errors (22 percent error rate). Of the remaining 64 selected from periods other than April to August 1999, 26 contained errors (40.6 percent error rate). Thus the sample items selected from the period that the plan contends was more vulnerable to errors actually had a lower error rate. Therefore, we continue to recommend for an immediate refund of \$35,639 with the remainder to be settled pending the outcome of the plan's complete review of institutional members.

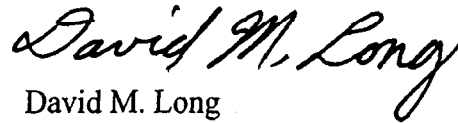
Final determinations as to actions to be taken on all matters will be made by the HHS official below. The HHS action official will contact you to resolve the issues in the audit report. Any additional comments or information that you believe may have a bearing on the resolution of this audit may be presented at that time. Should you have any questions, please direct them to the HHS official.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), reports issued by OIG, Office of Audit Services to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (see 45 CFR part 5).

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To facilitate identification, please refer to Common Identification Number A-03-00-00010 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink that reads "David M. Long". The signature is written in a cursive style with a large, stylized "D" and "L".

David M. Long
Regional Inspector General
for Audit Services

HHS Official

Regional Administrator
Health Care Financing Administration
Suite 216
150 S. Independence Mall West
Philadelphia, Pennsylvania 19106

APPENDIX A

VARIABLE APPRAISAL OF STATISTICAL SAMPLES

Universe (Beneficiaries)	1,528
Sample Size	100
Nonzero Items	34
Value of Nonzero Items	\$35,639
Mean	356.39
Standard Deviation	971.56
Standard Error	93.92
Skewness	6.74
Kurtosis	57.76
Point Estimate	\$544,558
Projection at the 90 Percent Confidence Level	
Lower Limit	\$306,269
Upper Limit	\$782,848
Precision Amount	\$238,290
Precision Percent	43.76

APPENDIX B

PSGHP RESPONSE



October 12, 2000

David M. Long, Regional Inspector General
Department of Health & Human Services
Office of Inspector General
Office of Audit Services
150 S. Independence Mall West, Suite 316
Philadelphia, PA 19106-3499

Re: Audit of Geisinger Health Plan Gold Institutionalized Members
Common Identification Number A-03-00-00010

Dear Mr. Long:

Thank you for allowing Geisinger Health Plan ("GHP") the opportunity to respond to the draft report issued as a result of your review of Medicare payments for beneficiaries reported as institutionalized by GHP between January 1, 1997 to December 31, 1999. The appropriate management staff reviewed the draft report and offers the following comments in response to the review and resulting recommendations:

Results of Review

The Office of Inspector General ("OIG") sampled 100 members from the universe provided by HCFA. From that sample, the OIG report noted 35 overpayments to GHP. GHP reviewed the 35 errors reported and takes exception to the following four cases:

1. - Medicare ID# Following the HMO/CMP manual in effect at the time of the service, GHP requested payment for the months of February and July 1997. The member was institutionalized from 1/24/97-2/25/97 at and again on 6/20/97-7/31/97 at
2. - Medicare ID# Following the HMO/CMP manual in effect at the time of service, GHP requested payment for March 1997. The member was institutionalized at Nursing Home from 2/18/97-3/27/97.
3. - Medicare ID# Following OPL #54 issued on 7/24/97, GHP requested payment for the months of April 1998-September 1999. The member was institutionalized on 3/27/98 and remains institutionalized at present.
4. - Medicare ID# Following both the HMO/CMP manual and OPL #54, GHP requested payment for the months of December 1996-January 1998. The member was institutionalized from 9/7/95-2/11/98.

In addition to these four cases being incorrect, GHP underwent a comprehensive computer conversion in April 1999 which resulted in inaccuracies in processing and verification of institutionalized members during the period April-August 1999. Therefore, GHP thinks that the statistical sample could be an inflated reflection of the actual number of errors.

Internal Controls

As a result of the 1999 HCFA Site Review, GHP revised its policy for identifying and reporting its institutionalized membership to HCFA. Enclosed is a copy of the revised policy number AME142, Institutionalized Status of Gold Members. This policy was submitted to HCFA on August 11, 2000, is pending approval and is operational.

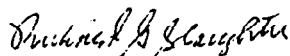
Concurrence/Nonconcurrence with OIG Conclusions and Recommendations

OIG recommends that GHP:

1. refund the estimated overpayments of \$312,348 as identified in their sample,
2. review the balance of 1,428 beneficiaries reported in institutional status between January 1, 1997 and December 31, 1999 and not included in the OIG sample to identify and refund additional overpayments that OIG estimates to be \$238,127 (this figure representing the difference between the \$312,348 sample lower limit estimate and the \$550,475 sample point estimate),
3. review the records of institutional status beneficiaries identified since December 31, 1999 and refund any overpayments; and,
4. strengthen the internal controls for identifying, monitoring and billing Medicare program for institutional status beneficiaries.

GHP agrees that errors did occur between January 1, 1997 and December 31, 1999 resulting in overpayments. However, because of the potential skew to the statistical sample previously noted, GHP does not concur with the estimated error rate utilized to calculate the overpayments noted. Due to this potential skew and consistent with HCFA's recommendation following the September 1999 Site Review, GHP proposes to perform a complete manual audit of all Medicare membership for the period January 1, 1997 through December 31, 2000. GHP proposes to complete this manual review by March 31, 2001. Upon completion of that audit, GHP will submit a reconciliation report to HCFA and the OIG reflecting both overpayments and underpayments and will settle with HCFA accordingly. Also, GHP continues to work on strengthening its internal controls for identifying, monitoring and billing Medicare for institutional status beneficiaries.

Sincerely,



Richard G. Slaughter
Vice President, Health Plans, Medicare

cc: Robert Baiocco, Senior Auditor, OIG Office of Audit Services
John Whalen, Regional Administrator, HCFA Region III